TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMS

PART 149
DIAGNOSIS RELATED GROUPING (DRG) PROSPECTIVE PAYMENT SYSTEM (PPS)

Section

AUTHORITY: Implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI, VII and 12-13].

SOURCE: Recodified from 89 Ill. Adm. Code 140.940 through140.972 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 12095, effective July 15, 1988; amended at 13 Ill. Reg. 554, effective January 1, 1989; amended at 13 Ill. Reg. 15070, effective September 15, 1989; amended at 15 Ill. Reg. 1826, effective January 28, 1991; emergency amendment at 15 Ill. Reg. 16308, effective November 1, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 6195, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11937, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14733, effective October 1, 1992, for a

maximum of 150 days; amended at 16 Ill. Reg. 19868, effective December 7, 1992; amended at 17 Ill. Reg. 3217, effective March 1, 1993; emergency amendment at 17 Ill. Reg. 17275, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3378, effective February 25, 1994; amended at 19 Ill. Reg. 10674, effective July 1, 1995; amended at 21 Ill. Reg. 2238, effective February 3, 1997; emergency amendment at 22 Ill. Reg. 13064, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 19866, effective October 30, 1998; amended at 25 Ill. Reg. 8775, effective July 1, 2001; amended at 26 Ill. Reg. 13676, effective September 3, 2002; emergency amendment at 27 Ill. Reg. 11080, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18872, effective November 26, 2003; amended at 28 Ill. Reg. 2836, effective February 1, 2004.

Section 149.5 Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)

a) Sections 149.25 through 149.150 describe:

1) The basis of payment for inpatient hospital services under the DRG PPS and set forth the general basis for the system;

2) Classifications of hospitals that are included and excluded from the DRG PPS and the requirements governing inclusion or exclusion of hospitals in the system as a result of changes in their classification;

3) Conditions that must be met for a hospital to receive payment under the DRG PPS;

4) The methodology by which DRG prospective rates are determined;

5) The methodology for determining additional payments for outlier cases;

6) The rules for special treatment of certain facilities; and

7) The types, amounts and methods of payment to hospitals under the DRG PPS.

b) Notwithstanding any other provisions of this Part, reimbursement to hospitals for services provided October 1, 1992, through March 31, 1994, shall be as follows:

1) Base Inpatient Payment Rate. For inpatient hospital services rendered, or, if applicable, for inpatient hospital admissions occurring, on and after October 1, 1992, and on or before March 31, 1994, the Department shall reimburse hospitals for inpatient services at the base inpatient payment rate calculated for each hospital, as of June 30, 1993. The term "base inpatient payment rate" shall include the reimbursement rates calculated effective October 1, 1992, under Part 149.

2) Exceptions. The provisions of subsection (b)(1) above shall not apply to:

A) Hospitals reimbursed under 89 Ill. Adm. Code 148.82, 148.160, or 148.170. Reimbursement for such hospitals shall be in accordance with 89 Ill. Adm. Code 148.82, 148.160, or 148.170, as applicable.

B) Hospitals reclassified as rural hospitals as described in 89 Ill. Adm. Code 148.40(f)(4). Reimbursement for such hospitals shall be in accordance with 89 Ill. Adm. Code 148.40(f)(4) and 148.260, or

Section 149.100(c)(1)(A), whichever is applicable.

C) The inpatient payment adjustments described in 89 Ill. Adm. Code 148.120, 148.150, and 148.290. Reimbursement for such inpatient payment adjustments shall be in accordance with 89 Ill. Adm. Code 148.120, 148.150, and 148.290, and shall be in addition to the base inpatient payment rate described in subsection (b)(1) above.

c) Definitions
Unless specifically stated otherwise, the definitions of terms used in this Part are as follows:

1) "DRG grouper" means:

A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the HCFA Medicare DRG grouper in effect on September 1, 1992, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(1).

B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the HCFA Medicare DRG grouper which is in effect 90 days prior to the date of admission, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(1).

2) "Medicare weighting factor" means:

A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the Medicare DRG weighting factors in effect on September 1, 1992, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(2).

B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Medicare DRG weighting factors in effect 90 days prior to the date of admission, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(2).

3) "PPS Pricer" means:

A) For the rate period described in 89 Ill. Adm. Code

148.25(g)(2)(A), the HCFA Medicare PPS Pricer, Version 92.0.

B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the HCFA Medicare PPS Pricer version that is in effect 90 days prior to the date of admission.

4) "Marginal Cost Factor":

A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the marginal cost factor shall be the same as that employed by Medicare on September 1, 1992.

B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the marginal cost factor shall be the same as that employed by Medicare 90 days prior to the date of admission.

5) "Cost Outlier Threshold":

A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the cost outlier threshold shall be the same as that employed by Medicare on September 1, 1992, adjusted for the differences in Medicare and Medicaid policies and population, as described in Section 149.100(a)(1).

B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the cost outlier threshold/fixed loss threshold shall be the same as that employed by Medicare 90 days prior to the date of admission.

(Source: Amended at 19 Ill. Reg. 10674, effective July 1, 1995)

Section 149.10 Applicability of Other Provisions

The following provisions, in addition to those provisions specifically cited in this Part, shall apply to hospitals reimbursed under the DRG PPS:

a) Participation, as described in 89 Ill. Adm. Code 148.20.

b) Definitions and Applicability, as described in 89 Ill. Adm. Code 148.25.

c) General requirements, as described in 89 Ill. Adm. Code 148.30.

d) Special requirements, as described in 89 Ill. Adm. Code 148.40.

e) Covered hospital services, as described in 89 Ill. Adm. Code 148.50.

f) Services not covered as hospital services, as described in 89 Ill. Adm. Code 148.60.

g) Limitations on hospital services, as described in 89 Ill. Adm. Code 148.70.

h) Hospital outpatient and hospital-based clinic services, as described in 89 Ill. Adm. Code 148.140.

i) Payment for pre-operative days, patient specific orders, and services which can be performed in an outpatient setting, as described in 89 Ill. Adm. Code 148.180.

j) Copayments, as described in 89 Ill. Adm. Code 148.190.

k) Filing cost reports, as described in 89 Ill. Adm. Code 148.210.

l) Review procedure, as described in 89 Ill. Adm. Code 148.310.

(Source: Amended at 18 Ill. Reg. 3378, effective February 25, 1994)

Section 149.25 General Provisions

a) Basis of Payment

1) Payment on a Per Discharge Basis

A) Under the DRG PPS, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.

B) The DRG prospective payment rate for each discharge (as defined in subsection (b) below) is determined according to the methodology described in Sections 149.100 and 149.150, as appropriate. An additional payment is made, in accordance with Sections 149.105 and 149.125, as appropriate. The rates paid shall be those in effect on the date of admission.

2) Payment in Full

A) The DRG prospective payment amount paid for inpatient hospital services is the total Medicaid payment for the inpatient operating costs (as described in subsection (a)(3) below) incurred in furnishing services covered under the Medicaid Program.

B) Except as provided for in subsection (b) below, the full DRG prospective payment amount, as determined under Sections 149.100 and 149.150, as appropriate, is made for each stay during which there is at least one Medicaid eligible day of care.

3) Inpatient Operating Costs. The DRG PPS provides a payment amount for inpatient operating costs, including:

A) Operating costs for routine services (as described in 42 CFR 413.53(b), revised as of September 1, 1990), such as the costs of room, board, and routine nursing services;

B) Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;

C) Special care unit operating costs (intensive care type unit services as described in 42 CFR 413.53(b), revised as of September 1, 1990);

D) Malpractice insurance costs related to services furnished to inpatients; and

E) Hospital-based physician costs as described in Section 149.75(h)(1)(A).

4) Excluded Costs/Services. The following inpatient hospital costs are excluded from the DRG prospective payment amounts:

A) Transplantation costs, including acquisition costs incurred by approved transplantation centers as described in 89 Ill. Adm. Code 148.82. Kidney and cornea transplant costs shall be reimbursed under the appropriate methodology described in Sections 149.100 and 149.150 or in 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.

B) Costs of psychiatric services incurred by a provider enrolled with the Department to provide those services (category of service 21). Such services shall be reimbursed under 89 Ill. Adm. Code 148.270(b).

C) Costs of nonemergency psychiatric services incurred by a provider that is not enrolled with the Department to provide those services (category of service 21). Such services shall not be eligible for reimbursement.

D) Costs of emergency psychiatric services exceeding the maximum of three days emergency treatment incurred by a provider that is not enrolled with the Department to provide those services (DRGs 424-432). Such services exceeding the maximum of three days shall not be eligible for reimbursement.

E) Costs of physical rehabilitation services incurred by a provider enrolled with the Department to provide those services (category of service 22). Such services shall be reimbursed under 89 Ill. Adm. Code 148.270(b).

F) Costs of rehabilitation for drug and alcohol abuse (DRG 436 and that part of DRG 437 apportioned to rehabilitation). Such services shall be reimbursed under 89 Ill. Adm. Code 148.340 through 148.390.

5) Additional Payments to Hospitals. In addition to payments based on the

DRG prospective payment rates, hospitals will receive payments for the following:

A) Atypically long or extraordinarily costly (outlier) cases, as described in Section 149.105.

B) Certain costs excluded from the prospective payment rate under subsection (a)(4) above.

C) The cost of serving a disproportionately high share of low income patients (as defined and determined in Section 149.125(a)(2)).

D) Specific inpatient payment adjustments (as defined and determined in Section 149.125(a)(3)).

b) Discharges and Transfers

1) Discharges. A hospital inpatient is considered discharged when any of the following occurs:

A) The patient is formally released from the hospital, except when the patient is transferred to another hospital or a distinct part unit as described in Section 149.50(d) (see subsection (b)(2) below).

B) The patient dies in the hospital.

2) Transfers. A hospital inpatient is considered transferred when the patient is placed in the care of another hospital or a distinct part unit as described in Section 149.50(d).

3) Payment in Full to the Discharging Hospital. The hospital discharging an inpatient (subsection (b)(1)(A) above) is paid in full, in accordance with subsection (a)(2) above, unless the discharging hospital or distinct part unit is excluded from the DRG PPS as described in Section 149.50(b), (c) and (d). In the event the discharging hospital or distinct part unit is excluded or exempted from the DRG PPS, that hospital or distinct part unit shall receive payment in full in accordance with 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.

4) Payment to a Hospital Transferring an Inpatient to Another Hospital or Distinct Part Unit

A) A hospital reimbursed under the DRG PPS that transfers an

inpatient, under the circumstances described in subsection (b)(2), is paid a per diem rate for each day of the patient's stay in that hospital but the total reimbursement shall not exceed the amount that would have been paid under Section 149.100 if the patient had been discharged. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under Section 149.100) by the geometric length of stay for the specific DRG to which the case is classified.

B) Except, if a discharge is classified into DRGs 385 or 985 (neonates, died or transferred to another acute care facility) or DRG 456 (burns, transferred to another acute care facility), and the hospital is reimbursed under the DRG PPS, the transferring hospital is paid in accordance with subsection (a)(2).

C) A transferring hospital reimbursed under the DRG PPS may qualify for an additional payment for extraordinarily high cost cases that meet the criteria for cost outliers as described in Section 149.105.

D) A hospital or distinct part unit excluded from the DRG PPS, as described in Section 149.50(b), (c) or (d), that transfers an inpatient under the circumstances described in subsection (b)(2) of this Section, is reimbursed in accordance with 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.

c) Admissions Prior to September 1, 1991. With respect to admissions prior to September 1, 1991, hospitals will receive their per diem reimbursement rate that was in effect July 1, 1991, for each covered day of care provided through the discharge of the patient.

d) DRG Classification System

1) The Department will utilize the DRG Grouper, as described in Section 149.5(c)(1), modified to handle additional DRGs and revised ICD-9-CM codes, as defined by the Department, to place claims into DRG payment classifications.

2) The Department will define additional DRGs that, for hospitals designated as Level III perinatal centers by the Illinois Department of Public Health, replace DRG 385 (neonates, died or transferred to another acute care facility), DRG 386 (extreme immaturity or respiratory distress syndrome, neonate), DRG 387 (prematurity with major problems) and DRG 389 (full

term neonate with major problems).

(Source: Amended at 19 Ill. Reg. 10674, effective July 1, 1995)

Section 149.50 Hospital Services Subject to and Excluded from the DRG Prospective Payment System

a) Hospital Services Subject to the DRG Prospective Payment System

1) Except for services described in Section 149.25(a)(4) and subsection (b)(2) below, all covered inpatient hospital services furnished to persons receiving coverage under the Medicaid Program are paid for under the DRG PPS.

2) Inpatient hospital services will not be paid for under the DRG PPS under any of the following circumstances:

A) The services are furnished by a hospital (or distinct part hospital unit) explicitly excluded from the DRG PPS under subsections (c) through (d) below.

B) The services are furnished by a nonparticipating out-of-state hospital (as described in subsection (c)(5) below).

C) The services are furnished by a hospital that elects to be reimbursed under special arrangements (as described in subsection (c)(6) below) in the transition period of DRG PPS implementation.

D) The services are furnished by a sole community hospital (as defined in Section 149.125(b)) that has elected to be exempted from the DRG PPS in accordance with subsection (c)(7) below.

E) The payment for services is covered by a health maintenance organization (HMO).

b) Excluded and Exempted Hospitals and Hospital Units: General Rules

1) Criteria. A hospital will be excluded from the DRG PPS if it meets the criteria for one or more of the classifications described in subsection (c) below.

2) Alternate Reimbursement System. All excluded hospitals (and excluded distinct part hospital units, as described in subsection (d) below) are reimbursed under the Alternate Reimbursement Systems set forth in 89 Ill. Adm. Code 148.250 through 148.300 with the exception of those hospitals described in subsection (c)(8) below. The hospitals described in subsection (c)(8) below are reimbursed in accordance with 89 Ill. Adm.

Code 148.160 or 148.170, as appropriate.

c) Excluded Hospitals: Classifications. Hospitals that meet the requirements for the classifications set forth in this Section may not be reimbursed under the DRG Prospective Payment System.

1) Psychiatric Hospitals. A psychiatric hospital must:

A) Be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and

B) Be enrolled with the Department as a psychiatric hospital to provide inpatient psychiatric services (category of service 21) and have a Provider Agreement to participate in the Medicaid Program.

2) Rehabilitation Hospitals. A rehabilitation hospital must:

A) Hold a valid license as a physical rehabilitation hospital; and

B) Be enrolled with the Department as a rehabilitation hospital to provide inpatient rehabilitation services (category of service 22) and have a Provider Agreement to participate in the Medicaid Program.

3) Children's Hospitals. To qualify as a children's hospital, the facility must have a Provider Agreement to participate in the Medicaid program and be either:

A) A hospital devoted exclusively to caring for children; or

B) A general care hospital which includes a facility devoted exclusively to caring for children that meets one of the following definitions:

i) A facility that is separately licensed as a hospital by a municipality prior to September 30, 1998. Such hospitals shall be reimbursed for all inpatient and outpatient services rendered to persons who are under 18 years of age, with the exception of obstetric, normal newborn nursery, psychiatric and rehabilitation, regardless of the physical location within the hospital complex where the care is rendered; or

ii) A facility that has been designated by the State as a Level

III perinatal care facility, has a Medicaid Inpatient Utilization Rate, as defined at 89 Ill. Adm. Code 148.12(k)(5), greater than 55 percent for the rate year 2003 disproportionate share determination, and has more than 10,000 qualified children days. Qualified children days means the number of hospital inpatient days for recipients under 18 years of age who are eligible under Medicaid, excluding days for normal newborn, obstetrical, psychiatric, Medicare crossover, and rehabilitation services, as determined from the Department's claims data for days occurring in State fiscal year 2001 that were adjudicated by the Department through June 30, 2002. Such hospitals shall be reimbursed for all inpatient and outpatient services rendered to persons who are under 18 years of age, with the exception of obstetric, normal newborn nursery, psychiatric and rehabilitation, regardless of the physical location within the hospital complex where the care is rendered.

4) Long Term Stay Hospitals. A long term stay hospital must:

A) Not be a psychiatric hospital, as described in subsection (c)(1) above, a rehabilitation hospital as described in subsection (c)(2) above, or a children's hospital as described in subsection (c)(3) above and must have an average length of inpatient stay greater than 25 days: as computed by dividing the number of total inpatient days (less leave or pass days) by the number of total discharges for the most recent State fiscal year for which complete information is available; and

B) Have a Provider Agreement to participate in the Medicaid Program.

5) Hospitals Outside of Illinois that are Exempt from Cost Reporting Requirements. A hospital is excluded from the DRG PPS if it meets the following definition: a nonparticipating out-of-state hospital is an out-of-state hospital that provides fewer than 100 Illinois Medicaid days annually, that does not elect to be reimbursed under this Part (the DRG Prospective Payment System), and that does not file an Illinois Medicaid cost report.

6) Hospitals Reimbursed Under Special Arrangements. Hospitals that, on August 31, 1991, had a contract with the Department under the ICARE

Program, pursuant to Section 3-4 of the Illinois Health Finance Reform Act, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care for services provided on or after September 1, 1991, subject to the limitations described in 89 Ill. Adm. Code 148.40(f) through 148.40(h).

7) Sole Community Hospitals. Hospitals described in Section 149.125(b), which have elected to be exempted from the DRG PPS, subject to the limitations described in 89 Ill. Adm. Code 148.40(f) through 148.40(h).

8) County-Owned Hospitals and Hospitals Organized Under the University of Illinois Hospital Act. County-owned hospitals located in an Illinois county with a population greater than three million and hospitals organized under the University of Illinois Hospital Act are excluded from the DRG system and are reimbursed under unique hospital-specific reimbursement methodologies as described in 89 Ill. Adm. Code 148.160 and 148.170.

d) Excluded Distinct Part Hospital Units

1) Distinct Part Psychiatric Units. With the exception of those hospitals described in subsections (c)(1) through (c)(8) above, a hospital enrolled with the Department to provide inpatient psychiatric services (category of service 21) shall be excluded from the DRG PPS for the reimbursement of such inpatient psychiatric services and shall be reimbursed in accordance with 89 Ill. Adm. Code 148.270(b).

2) Distinct Part Rehabilitation Units. With the exception of those hospitals described in subsections (c)(1) through (c)(8) above, a hospital enrolled with the Department to provide inpatient rehabilitation services (category of service 22) shall be excluded from the DRG PPS for the reimbursement of such inpatient rehabilitation services and shall be reimbursed in accordance with 89 Ill. Adm. Code 148.270(b).

(Source: Amended at 27 Ill. Reg. 18872, effective November 26, 2003

Section 149.75 Conditions for Payment Under the DRG Prospective Payment System

a) General Requirements

1) A hospital must meet the conditions of this Section to receive payment under the DRG PPS for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.

2) If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicaid clients, the Department may, as appropriate:

A) Withhold Medicaid payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or

B) Terminate the hospital's Provider Agreement pursuant to 89 Ill. Adm. Code 140.16.

b) Hospital Utilization Control. Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 456 (October 1, 1999). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in Section 149.50(c)(1), shall be in accordance with federal regulations.

c) Medical Review Requirements: Admissions and Quality Review

Hospital utilization review committees, a subgroup of the utilization review committee, or the hospital's designated professional review organization (PRO) shall review, on an ongoing basis, the following:

1) The medical necessity, reasonableness and appropriateness of inpatient hospital admissions and discharges.

2) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of Section 149.105.

3) The validity of the hospital's diagnostic and procedural information.

4) The completeness, adequacy and quality of the services furnished in the

hospital.

5) Other medical or other practices with respect to program participants or billing for services furnished to program participants.

d) Medical Review Requirements: DRG Validation

1) Coding attestation. Beginning with admissions on or after March 1, 1997, and ending with admissions on or after July 1, 2001, the Health Information Management Director (Medical Records) or his or her designee(s) within the Health Information Management Department must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest to the principal and secondary diagnoses, and major procedures as indicated in the medical record. Below the diagnostic and procedural information, and on the same page, the following statement must immediately precede the signature of the Health Information Management Director or his or her designee(s) within this Department: "I certify that the ICD-9-CM coding of principal and secondary diagnoses and the major procedures performed are accurate and complete based on the contents of the medical record, to the best of my knowledge." The name of the person signing the attestation must be typed or clearly printed and appear on the same page as the signature.

2) DRG Validation. The Department, or its designated peer review organization, may require and perform prepayment review and/or postpayment review of specific diagnosis and procedure codes.

3) Sample Reviews

A) The Department, or its designated peer review organization, may review a random sample of discharges to verify that the diagnostic and procedural coding, submitted by the hospital and used by the Department for DRG assignment, is substantiated by the corresponding medical records

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B) Code validation must be done on the basis of a review of medical records and, at the Department's discretion, may take place at the hospital or away from the hospital site

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4) Revision of Coding

A) If the diagnostic and procedural information, in compliance with the coding attestation requirements in subsection (d)(1) of this

Section, is found to be inconsistent with the hospital's coding, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.

B) If the information, in compliance with the coding attestation requirements in subsection (d)(1) of this Section, is found not to be consistent with the medical record, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.

e) Utilization Review Requirements: The Department, or its designated peer review organization (see 89 Ill. Adm. Code 148.240(j)), may conduct pre-admission, concurrent, pre-payment, and/or post-payment reviews, as defined at 89 Ill. Adm. Code 148.240.

f) Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements

1) The applicable payments made under the PPS are payment in full for all inpatient hospital services other than for the services of non hospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in subsections (f)(1)(B)(i) through (f)(1)(B)(v) of this Section.

A) Hospital-based physicians who may not bill separately on a fee-for-service basis:

i) A physician whose salary is included in the hospital's cost report for direct patient care may not bill separately on a fee-for-service basis.

ii) A teaching physician who provides direct patient care may not bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.

B) Hospital-based physicians who may bill separately on a fee-for-service basis:

i) A physician whose salary is not included in the hospital's cost report for direct patient care may bill separately on a fee-for-service basis.

ii) A teaching physician who provides direct patient care may bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.

iii) A resident may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and collect and retain the payments received for those services.

iv) A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she may charge for professional services and does, in fact, bill private patients and collect and retain the payments received.

v) A physician holding a non teaching administrative or staff position in a hospital or medical school may bill separately on a fee-for-service basis to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.

2) Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

(Source: Amended at 26 Ill. Reg. 13676, effective September 3, 2002)

Section 149.100 Basic Methodology for Determining DRG Prospective Payment Rates

a) DRG Classification and Weighting Factors

1) DRG Classification. The Department will utilize the DRG Grouper, as described in Section 149.5(c)(1), to classify inpatient hospital discharges by diagnosis related groups (DRGs) as defined by federal regulation for the Medicare Program (42 CFR 412), with modifications deemed appropriate due to the differences in the Medicare and Medicaid patient populations and Illinois Medicaid policy.

2) DRG Weighting Factors

A) Except as provided in subsections (a)(2)(B) through (a)(2)(E) below, the Illinois Medicaid weighting factor for each DRG shall equal the Medicare weighting factor, as described in Section 149.5(c)(2), for that group, multiplied by a fraction, the numerator of which is the Medicaid geometric mean length of stay and the denominator of which is the Medicare geometric mean length of stay for that group. In making that calculation, the Department shall:

i) Use the Medicare geometric mean length of stay for each diagnostic related group as determined by the Health Care Financing Administration of the United States Department of Health and Human Services.

ii) Calculate the Medicaid geometric mean length of stay for each diagnostic related group using the same methodology employed to calculate the Medicare geometric mean length of stay and using data obtained from the Illinois Health Care Cost Containment Council or the Department's data bases.

B) The Illinois weighting factors for neonatal discharges (Medicare-defined DRGs 385-391 and Illinois-defined DRGs for Level III perinatal centers) shall be the product of the ratio of the mean cost per discharge (defined below) of the given DRG to the mean cost per discharge for DRG 391 (normal newborn) and the Medicare scaling factor (defined below), such that the Illinois and Medicare weighting factors for DRG 391 are the same.

i) Mean cost per discharge, for any DRG, is defined as the

sum of the product of charges, as reported by a hospital on claims paid by the Department, less costs for capital, direct and indirect medical education, updated to the current rate year using the national hospital market basket price proxies (DRI) and the hospital's cost to charge ratio, as derived from the hospital's most recent audited cost report, divided by the number of discharges for that DRG.

ii) Medicare scaling factor is defined as the Medicare weighting factor for DRG 391 (normal newborns).

C) The Illinois weighting factors for psychiatric discharges (DRGs 424-432) shall be computed as specified in subsections (a)(1) and (a)(2) except, prior to computing the Medicaid geometric mean length of stay for those DRGs, all lengths of stay longer than three (3) days are to be set at three (3) days.

D) The Illinois weighting factors for DRGs that will not be paid through the DRG PPS are zero (0.0000). Those include DRG 103, heart transplant; DRG 436, alcohol/drug dependence with rehabilitation therapy; DRG 462, rehabilitation; DRG 480, liver transplant; DRG 481, bone marrow transplant; DRG 495, lung transplant.

E) Except for DRGs otherwise specified in subsections (a)(2)(B) through (a)(2)(D), the Illinois weighting factors for DRGs for which available historic discharge data are sparse, fewer than 100 records, shall be computed using an alternate methodology.

i) For rate periods beginning on or after October 1, 1992, for those DRGs with 32 or more records available, the Illinois weighting factor shall be set at the midpoint between the weight calculated using the methodology in subsection (a)(2)(A) and the Medicare weighting factor, as described in Section 149.5(c)(2).

ii) For those DRGs with fewer than 32 records available, the Illinois weighting factor shall be set equivalent to the Medicare weighting factor, as described in Section 149.5(c)(2).

3) Assignment of Discharges to DRGs. The Department will establish a methodology for classifying specific hospital discharges within DRGs

which ensures that each hospital discharge is appropriately assigned to a single DRG, based on essential data abstracted from the inpatient bill for that discharge.

A) The classification of a particular discharge will, as appropriate, be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status.

B) Each discharge will be assigned to only one DRG (related, except as provided in subsection (a)(3)(C), to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

C) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill will be subject to prepayment review for validation and reverification. The Department's DRG classification system will provide a DRG, and an appropriate weighting factor, for cases for which the unrelated diagnosis and procedure are confirmed.

4) Review of DRG Assignment

A) A hospital has 60 days after the date of the remittance advice indicating initial assignment of a discharge to a DRG to request a review of the assignment. The hospital may submit additional information as a part of its request.

B) The Department shall review the hospital's request and any additional information and decide whether a change in the DRG assignment is appropriate. If the Department decides that a higher-weighted DRG should be assigned, it must request the Department's peer review organization to review the case to verify the change in DRG assignment.

C) Following the 60-day period described in subsection (a)(4)(A) above, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

b) Illinois Rates for Admissions

1) Reimbursement to hospitals for claims for admissions occurring prior to

October 1, 1992, shall be calculated and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered. The payments described in Sections 149.5 through 149.150 and 89 Ill. Adm. Code 148.250 through 148.300 shall be effective for admissions on and after October 1, 1992, subject to 89 Ill. Adm. Code 148.20(b) and Section 149.5(b).

2) The payments described in 89 Ill. Adm. Code 148.82 shall be effective for services provided on or after July 1, 1992.

c) Determining Prospective Payment Rates.

1) Federal/Regional Blended Rate Per Discharge

A) Except as specified in subsection (c)(1)(B) below, the Department shall reimburse hospitals for inpatient services at the federal/regional blended rate per discharge for the Medicare Program, which includes the hospital-specific portion as described in subsection (c)(2) below, if applicable, and as computed by the PPS Pricer, as described in Section 149.5(c)(3).

B) In the case of a hospital that was not determined by the Department to be a rural hospital at the beginning of the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), but was subsequently reclassified by the Department as a rural hospital, as described in 89 Ill. Adm. Code 148.25(g)(3), on July 15, 1993:

i) Effective with admissions occurring on October 1, 1993, and for the duration of the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the Department shall recompute such hospital's DRG PPS payment rate using the rural hospital federal/regional, rural wage adjusted, blended rate per discharge in effect on September 1, 1992, under the Medicare Program.

ii) Effective with admissions occurring on or after the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall compute such hospital's DRG PPS payment rate using the rural hospital federal/regional, rural wage adjusted, blended rate per discharge in effect 90 days prior to the date of admission, under the Medicare Program.

2) Hospital-Specific Portion

The hospital-specific portion is defined as the specific status and any applicable add-ons under the Medicare Program in recognition of sole community hospitals, rural referral centers, Medicare dependent hospitals, and rural hospitals deemed urban.

3) DRG PPS Base Rate

The DRG PPS base rate shall be defined as the sum of the amounts computed under subsections (c)(1) and (c)(2), multiplied by the Illinois weighting factor assigned to the DRG into which the case has been classified.

4) Payment Adjustments
In addition to the DRG PPS base rate defined in subsection (c)(3), hospitals shall receive applicable outlier adjustments, in accordance with Section 149.105; applicable adjustments for capital costs in accordance with Section 149.150(c); applicable adjustments for disproportionate share, in accordance with 89 Ill. Adm. Code 148.120; applicable adjustments for uncompensated care, in accordance with 89 Ill. Adm. Code 148.150; various specific inpatient payment adjustments, as applicable, in accordance with 89 Ill. Adm. Code 148.290.

d) Application of Upper Payment Limits
The Department shall adjust each of the prospective payment rates determined under subsection (c) above (with the exception of disproportionate share payment adjustments made in accordance with 89 Ill. Adm. Code 148.120) to ensure that aggregate payments do not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles, in compliance with 42 CFR 447.272, Application of Upper Payment Limits.

(Source: Amended at 19 Ill. Reg. 10674, effective July 1, 1995)

Section 149.105 Payment For Outlier Cases

a) General Provisions

1) Except as provided in subsections (a)(3) and (a)(4) of this Section, the Department provides for additional payment, approximating a hospital's marginal cost of care beyond thresholds specified by the Department, to a hospital for covered inpatient hospital services furnished to a Medicaid client, if either of the conditions in the following subsections (A) or (B) apply. The client's length of stay (including up to three administrative days) exceeds the day outlier threshold, determined by the Department, for the appropriate applicable DRG.

A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the threshold is set at the lesser of the geometric mean length of stay plus 27 days, or the geometric mean length of stay plus three standard deviations.

B) For rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall utilize the geometric mean length of stay plus the lesser of three standard deviations, or the Medicare day outlier cutoff threshold in effect 90 days prior to the date of admission, adjusted by a factor, the numerator of which is the Medicaid geometric length of stay, and the denominator of which is the average Medicare geometric mean length of stay.

2) The hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost-to-charge ratio, as described in subsection (c)(3) of this Section, exceed the greater of:

A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), $34,000 as adjusted for the hospital's labor market, or the hospital's DRG PPS base rate as described in Section 149.100(c)(1) multiplied by two.

B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall utilize the Medicare established cost outlier cutoff threshold in effect 90 days prior to the date of admission.

3) The Department will provide cost outlier payments to a transferring hospital reimbursed under the DRG PPS that does not receive payment under subsection (b) of this Section for discharges specified in Section

149.25(b)(4)(B), if the hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost-to-charge ratio, as described in subsection (c)(3), exceed:

A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the greater of the criteria specified in subsection (a)(2)(A) of this Section.

B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the criteria specified in subsection (a)(2)(B) of this Section.

4) The Department will not provide outlier payments for:

A) Discharges classified as psychiatric care (DRGs 424-432). Such care provided by other than hospitals or distinct part units enrolled with the Department to provide psychiatric care (category of service 21) is limited to emergency treatment, to last no longer than three days.

B) Discharges assigned to DRGs with an Illinois weighting factor of zero (0.0000).

5) The Department or its designee may review outlier cases on a prepayment or postpayment review basis. The charges for any services identified as noncovered through this review will be denied and any outlier payment having been made for those services will be recovered, as appropriate, after a determination as to the provider's liability has been made. If the Department or its designee finds a pattern of inappropriate utilization by a hospital, all outlier cases from that hospital are subject to medical review, and this review may be conducted prior to payment until the Department or its designee determines that appropriate corrective actions have been taken. The Department, or its designee, must review and approve, to the extent required by the Department:

A) The admission was medically necessary and appropriate.

B) The medical necessity and appropriateness of the admission and outlier services in the context of the entire stay.

C) The services were ordered by the physician, actually furnished, and nonduplicatively billed.

D) The validity of the diagnostic and procedural coding.

E) The granting of up to three administrative (grace) days during which the hospital is seeking an appropriate setting into which to discharge a nonacute patient.

b) Payment for Extended Length-of-Stay Cases (Day Outliers)

1) If the hospital stay includes covered days of care beyond the applicable threshold criterion, the Department will make an additional payment, on a per diem basis, to the discharging hospital for those days and the transferring hospital for DRG's 385, 456, or 985 only. A special request or submission is not necessary to initiate this payment.

2) Except as provided in subsection (d) of this Section, and subject to the limitations described in subsection (e) of this Section, the per diem payment made under subsection (b)(1) is derived by first taking the marginal cost factor, as defined in 149.5(c)(4), of the per diem payment for the applicable DRG, as calculated by dividing the DRG PPS base rate, determined under Section 149.100(c)(3), by the mean length-of-stay for that DRG.

3) Any days in a covered stay identified as noncovered reduce the number of days reimbursed at the day outlier rate but not to exceed the number of days that occur after the day outlier threshold.

c) Payment for Extraordinarily High Cost Cases (Cost Outliers)

1) If the hospital charges, as adjusted by the method specified in subsection (c)(3), exceed the applicable threshold criterion, the Department will make an additional payment to the hospital to cover those costs. A special request or submission is not necessary to initiate this payment.

2) The Department will reimburse the cost of the discharge on the billed charges for covered inpatient services, adjusted by a cost-to-charge ratio as described in subsection (c)(3), subject to the limitations described in subsections (c)(4) and (e) of this Section.

3) The cost-to-charge ratio used to adjust covered charges is computed at the beginning of each rate period, as described in 89 Ill. Adm. Code 148.25(g)(2), by the Department for each hospital based on the hospital's base fiscal year. Statewide cost-to-charge ratios are used in those instances in which a hospital's cost-to-charge ratio falls outside reasonable

parameters or cannot be computed due to a lack of information (e.g., a new hospital for which the Department is not in possession of the required historical information).

4) If any of the services are determined to be noncovered, the charges for those services will be deducted from the requested amount of reimbursement but not to exceed the amount claimed above the cost outlier threshold.

5) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall employ the same methodologies and rates used by Medicare, to calculate additional payments for cost outliers.

d) Payment for Extraordinarily High Cost Day Outliers. If a discharge qualifies for an additional payment under the provisions of both subsections (b) and (c), the additional payment is, subject to the limitations described in subsection (e) of this Section, the greater of the following:

1) The payment computed under subsection (b) above.

2) The payment computed under subsection (c) above.

e) Outlier Payment Limitation. Notwithstanding any other provisions of this Section, the total reimbursement paid by the Department excluding payments described in 89 Ill. Adm. Code 148.120 for a claim qualifying for an outlier payment under this Section shall not exceed the total covered inpatient charges.

(Source: Amended at 19 Ill. Reg. 10674, effective July 1, 1995)

Section 149.125 Special Treatment of Certain Facilities

a) General Rules

1) Sole Community Hospitals. Hospitals defined as sole community hospitals under subsection (b) below, shall have the choice of being reimbursed under the DRG PPS methodology, as described in Sections 149.5 through 149.150, or the Department's Alternate Reimbursement methodology as described in 89 Ill. Adm. Code 148.250 through 148.300, in accordance with the provisions of 89 Ill. Adm. Code 148.40(f) through (h).

2) Hospitals that Serve a Disproportionate Share of Low Income Patients. The Department shall make additional payments to hospitals that serve a disproportionate share of low income patients. The criteria and methodologies for such additional payments are set forth in 89 Ill. Adm. Code 148.120.

3) Specific Inpatient Payment Adjustments. The Department shall make specific additional payments to applicable hospitals as set forth in 89 Ill. Adm. Code 148.290.

b) Criteria for Classification as a Sole Community Hospital. "Medicaid Sole Community Provider" means a hospital that meets one of the following criteria:

1) Medicare Program Designation

A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare Program effective September 1, 1992.

B) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(B), any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare Program effective 90 days prior to the date of admission.

2) Primary Service Area Designation

A) Any rural hospital, as described in 89 Ill. Adm. Code 148.25(g)(3), that serves 55 percent or more of the Medicaid patients residing

within the hospital's primary service area for the provision of inpatient hospital services.

B) "Primary service area" means the geographic area defined by U.S. Postal Service Zip Codes in which 50 percent or more of a hospital's inpatients reside.

3) The determination of sole community provider status under this subsection (b) shall be made prior to the rate period, as described in 89 Ill. Adm. Code 148.25(g)(2).

4) The data used to make this determination will be from the Illinois Health Care Cost Containment Council (IHCCCC) for the most recent four quarters for which information is available.

(Source: Amended at 19 Ill. Reg. 10674, effective July 1, 1995)

Section 149.140 Methodology for Determining Primary Care Access Health Care Education Payments (Repealed)

(Source: Repealed at 19 Ill. Reg. 10674, effective July 1, 1995)

Section 149.150 Payments to Hospitals Under the DRG Prospective Payment System

a) Total Medicaid Payment. Under the DRG PPS, the total payment for inpatient hospital services furnished to a Medicaid client by a hospital will equal the sum of the payments listed in subsections (b) through (c). In addition to the payments listed in subsections (b) through (c) of this Section, hospitals shall also receive disproportionate share adjustments in accordance with 89 Ill. Adm. Code 148.120, if applicable, uncompensated care adjustments in accordance with 89 Ill. Adm. Code 148.150, if applicable, and various specific inpatient payment adjustments in accordance with 89 Ill. Adm. Code 148.290, if applicable.

b) Payments Determined on a Per Case Basis. A hospital will be paid on a per case basis (with the exception of kidney acquisition costs) the following amounts:

1) the appropriate DRG PPS rate for each discharge as determined in accordance with Section 149.100(c).

2) The appropriate outlier payment amounts determined under Section 149.105.

3) Capital related costs as determined under subsection (c)(1)(A) of this Section.

c) Payments for Capital Costs. For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A) these costs shall be paid on a per case basis. For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), these costs shall be paid on a per diem basis. Payments for these costs shall be calculated as follows:

1) Capital Related Costs

A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A):

i) The capital related cost per diem shall be calculated by taking the hospital's total capital related costs as reported on the hospital's latest audited Medicare cost report on file with the Department for the base period as defined in 89 Ill. Adm. Code 148.25(g)(1), divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national total hospital market basket price proxies (DRI).

ii) These two trended capital related cost per diems are then

added together and divided by two to calculate the hospital's adjusted capital related cost per diem.

iii) The adjusted capital related cost per diem amount, as calculated in subsection (c)(1)(A)(ii) above, shall be rank ordered for all hospitals and capped at the 80th percentile.

iv) Each hospital shall receive a per case add-on for capital related costs which shall be equal to the amount calculated in subsection (c)(1)(A)(ii) or subsection (c)(1)(A)(iii) above, whichever is less, multiplied by the hospital's average length of stay for services reimbursed under the DRG PPS.

B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B):

i) Capital related cost per diem shall be calculated in accordance with subsections (c)(1)(A)(i) through (c)(1)(A)(iii) of this Section.

ii) Each hospital shall receive a per diem add-on for capital related costs which shall be equal to the amount calculated in subsection (c)(1)(A)(ii) or subsection (c)(1)(A)(iii) of this Section, whichever is less.

2) A hospital wishing to appeal the calculation of its rates must notify the Department within 30 days after receipt of the rate change notification.

d) Method of Payment

1) General Rule. Unless the provisions of subsection (d)(2) of this Section apply, hospitals are paid for each discharge based on the submission of a discharge bill. Payments for inpatient hospital services furnished by an excluded distinct part psychiatric or a rehabilitation unit of a hospital are made in accordance with 89 Ill. Adm. Code 148.270(b).

2) Special Interim Payment for Unusually Long Lengths of Stay

A) First Interim Payment. A hospital may request an interim payment after a Medicaid client has been in the hospital at least 60 days. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of

the last day for which services have been billed.

B) Additional Interim Payments. A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under subsection (d)(2)(A) of this Section. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of subsection (d)(2).

3) Outlier Payments. Except as provided in subsection (d)(2) of this Section, payment for outlier cases (described in Section 149.105) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment.

e) Reductions to Total Payments

1) Copayments. Copayments are assessed in accordance with 89 Ill. Adm. Code 148.190.

2) Third Party Payments. Hospitals shall determine that services rendered are not covered, in whole or in part, under any other state or federal medical care program or under any other private group indemnification or insurance program, health maintenance organization, preferred provider organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.

f) Effect of Change of Ownership on Payments Under the DRG Prospective Payment System. When a hospital's ownership changes, the following rule applies: Payment for the cost of inpatient hospital services for each patient, including outlier payments, as provided under subsection (b) of this Section, will be made to the entity that is the legal owner on the date of discharge. Payments will not be prorated between the buyer and seller.

1) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a Medicaid client regardless of when the client's coverage began or ended during a stay, or of how long the stay lasted.

2) Each bill submitted must include all information necessary for the Department to compute the payment amount, whether or not some of the

information is attributable to a period during which a different party legally owned the hospital.

(Source: Amended at 28 Ill. Reg. 2836, effective February 1, 2004)

Section 149.175 Payments to Contracting Hospitals (Repealed)

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.200 Admitting and Clinical Privileges (Repealed)

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.205 Inpatient Hospital Care or Services by Non-Contracting Hospitals Eligible for Payment (Repealed)

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.225 Payment to Hospitals for Inpatient Services or Care not Provided under the ICARE Program (Repealed)

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.250 Contract Monitoring (Repealed)

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.275 Transfer of Recipients (Repealed)

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.300 Validity of Contracts (Repealed)

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.305 Termination of ICARE Contracts (Repealed)

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.325 Hospital Services Procurement Advisory Board (Repealed)

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)